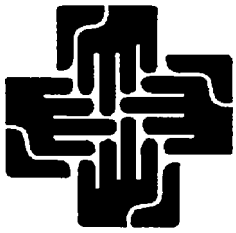
WORLD RELIEF CORPORATION (WRC)/ ORGANIZACION PROFESIONAL DE DESARROLLO (OPRODE) EL SALVADOR CHILD SURVIVAL IX PROJECT

San Salvador, El Salvador
FINAL EVALUATION
September 5, 1996



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I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

The projects measurable objectives are listed in table 1. The table presents data for each objective, comparing baseline survey, final survey and end-of-project goals.

Table 1: **DIP Objectives, Baseline and Final KPC Results, and EOP Goals (in percentage points)**

No.	Project Objectives	Baseline KPC	Final KPC	EOP Goal
1	**Maternal Care** Pregnant women will have at least 5 Antenatal care visits	9	47.4	30
2	Pregnant women will identify 3 risk signs in pregnancy	1	1	60
3	Women ages 15-45 will receive at least 2 doses of TT	18	45	50
4	**Diarrhea Control** Mothers with children 0-59 months who had diarrhea in the last 2 weeks will have administered ORT	43	58	70
5	Mothers who know 2 signs of dehydration	4	51.7	70
6	Mothers who give more food than usual to a child during recovery (at least 1 week) from diarrhea and/or ALRI	14	37	50
7	Mothers who give colostrum and exclusively breastfeed for at least 4 months	11	40	40
8	**Immunizations** Children 0-11 months completely immunized (denominator 12-23 month olds)	36	75	80
9	**ALRI** Mothers of children 0-23 months will be able to recognize rapid breathing as a sign of pneumonia for referral purposes	53	68	80
10	Mothers who seek advice or treatment from a health professional for a child with ALRI	62	98	80
11	**Birth Spacing** Couples (who are not pregnant and do not want another child in the next two years) who are using effective fertility control methods	35	36	50

The following table presents a summary of the six objectives that have the highest percentage of mothers in the project area who either know or practice the projects interventions. These are the interventions in which a critical number of mothers know or practice child survival interventions. Of special note is the very high percentage of

mothers who stated that they have sought help from a health professional when **there** are signs of respiratory infection. This practice, combined with the high percentage of mothers who recognize a risk sign for pneumonia, indicates that mothers in the project area have a high level of activity in reducing the risk of ALRI.

Table 2: Highest Percentage of Knowledge or Practice (in percentage points)

OBJECTIVES	BASE	FINAL
Mothers who **seek advice or treatment from** a health professional for a child **with ALRI**	62	**98**
Children O-l 1 months completely **immunized**	36	75
Mothers of children O-23 months will be able to recognize rapid breathing as a **sign of pneumonia** for referral purposes	53	68
Mothers with children O-59 months who had diarrhea in the last 2 weeks will have administered **ORT**	43	58
Mothers who **know 2 signs of dehydration**	4	51
Pregnant women will have at least 5 **Antenatal care** visits	9	48

Another way to assess the accomplishment of the project is to identify the interventions in which there has been greatest change from the baseline to the final survey. This analysis presents a perspective on the impact of the project on change in knowledge and practice. A summary of the areas in which there has been the greatest change, in terms of percentage points, is presented in table 3.

Table 3: Greatest Change from Baseline to Final Survey (in percentage points)

OBJECTIVE	BASE	FINAL	DIFF.
Mothers who **know 2 signs of dehydration**	4	51	47
Pregnant women will have **at** least 5 **Antenatal care** visits	9	48	39
Children O-l 1 months completely **immunized**	36	75	39
Mothers who **seek advice or treatment** from a health professional for a child with ALRI	62	98	36
Mothers who give colostrum and exclusively **breastfeed** for at least 4 months	11	40	29

It **is** noteworthy that four of the five interventions with the greatest change are behaviors. This is an indicator of substantive progress in the cycle of adoption of

innovation. The change in the adoption of exclusive breastfeeding is especially gratifying according to the promoters, since it was a very difficult practice for the mothers to accept. A high percentage of mothers have to work outside the home, and equipment and storage for breast pumping are almost nonexistent. Another difficult barrier is that mothers commonly believe their milk is not sufficient. Their strong desire that their babies be as healthy as possible (big and plump!) makes them want to give additional food, even though it runs counter to healthy practice.

Synthesizing the data from the above two tables offers a perspective on the interventions that have had the greatest impact as defined by both a high level of adoption and a high percentage of change. This combination is evidence of momentum for change that should continue after the project is completed. Table 4 lists these interventions.

Table 4: Interventions with Greatest Impact

INTERVENTION
Mothers who **seek advice or treatment** from a health professional for a child with **ALRI**
Children O-l 1 months completely **immunized**
Pregnant women **will** have **at** least **5 Antenatal care visits**

While the percentage of children immunized is still not at the level it should be, the progress from the baseline of 36% of children immunized is substantial. The staff from the MOH health centers recounted how difficult it was to get access to mothers for immunizations before the project began. Now all they have to do is provide the vaccines and perform the injections, the promoters, volunteers and health committees notify and organize the mothers. The MOH staff stated that the project would have been worthwhile if it had only been successful in this intervention.

Another intervention where there has been a high level of accomplishment is in the identification of risk signs in pregnancy, even though it is not indicted as such in the final survey results. While the percentage of mothers who could identify three risk signs is only l%, the number who could identify two signs was greater than 95%. This is an unusual gap in knowledge. The evaluator questioned the staff about potential reasons for the discrepancy between these numbers. The promoters stated that they observed many instances in the final survey where the interviewer did not prompt mothers for more answers when they asked this question. Many times the interviewer would record one or two answers and then continue on to the next question. The promoters feel very strongly that if prompted, the mothers would have identified more signs.

On the other hand, there are three interventions in which there was not much progress. These are the objectives of giving more food during recovery from an episode of diarrhea, ORT and birth spacing. In regards to ORT, while the percentage of mothers who use ORT is relatively high, it is disappointing that the percentage of change was not higher. This is a foundational practice for child survival. One possible reason is that a policy change occurred during the course of the project. Project staff began promoting the use of homemade ORS, but halfway through, the policy was changed to promoting the use of ORS packets. It may have caused confusion to tell mothers to stop using homemade solutions after just having learned to do so.

The lack of progress in birth spacing is due in part to the fact that the intervention was only introduced in the last year, which was according to plan One year is not enough to effectively address this issue in a conservative country like El Salvador. Additionally, most of the teaching was done with only mothers. Men need to be involved with their wives in learning about and discussing family planning.

Positive and Negative Effects of Proiect Activities

The accomplishments of this project can also be described according to statements from mothers and volunteers. The evaluation team facilitated 12 focus groups with a total of 127 mothers. They were asked to identify the most important changes they have seen since the project started. The most frequent responses from all the groups were as follows:

- Control and prevention of diarrhea
- Children vaccinated
- TT vaccinations for mothers

The frequency of these responses was consistent across the groups. Their identification of childhood vaccinations matches the survey data. Their high value on TT vaccinations, however, differs from the priority implied in the survey data. In regard to all vaccinations, the survey data may be lower than reality because mothers had to show their vaccination cards for the response to be validated. It is likely that more women had received their TT vaccinations but were not counted because they had lost their cards.

Mothers were also asked about personal benefits of the project. The most frequently mentioned responses were as follows:

- Knowing about where common childhood illnesses come from
- Knowing how to prevent and control diarrhea
- Knowing about hygiene
- Knowing how to respond to respiratory infections

It is interesting to note that control of diarrhea was highly valued in both focus **group** questions. It was also the change most frequently identified by the volunteers. This does not match data from the final survey, but it supports the conjecture that some confusion may have occurred because of the change in ORT strategy. The response of the focus groups indicated a high level of consciousness about control and prevention of diarrhea.

During the focus groups it was interesting to hear mothers discuss the value of having learned where diseases come from. In group after group they recounted how vulnerable they used to feel when their children got sick. They did not have any idea of what to do. Now they feel so much more confident because in many cases they know what to do. In fact, if they recognize the illness is not serious, they don't have to expend valuable time and resources taking their child to the doctor.

Another effect of the project is that mothers are no longer as passive as they were. The volunteers, promoters and supervisors all made the observation that mothers are much more active in preventing illness and in community affairs. The **project has** given them a higher level of self-confidence.

Volunteers from 12 communities were also interviewed in a focus format. Their responses to the question of the changes effected by the project matched the mothers' responses. The most frequently mentioned response was the change in control and prevention of diarrhea. When asked about the personal benefits of the project, the volunteers most frequently mentioned the general knowledge about health and disease prevention they had received.

An important accomplishment in this project has been the dramatic improvement in program implementation since the midterm evaluation. The staff took the midterm to heart and addressed all the areas in which they were deficient. For example, at the midterm only 60% of the volunteers had at-risk families assigned to them. Within a month of the midterm, all volunteers were assigned families. Eighty-five percent of the volunteers now faithfully track and follow-up their assigned families. The volunteers now take the leadership in home visits and health education sessions with mothers' groups. The supervisors and promoters organized quarterly training workshops where volunteers created their own problem-posing diagrams to use in home visits and health talks. Creating their own educational materials gave a great boost to the volunteers' self-esteem and made them all the more disposed to use this method instead of straight lecture. (See Appendix A for a sample of the problem-posing diagrams designed by the volunteers.)

Substantial improvement was also made in regard to the development of health committees. At the midterm less than 50% of the target communities had health committees. At the final evaluation, 32 of 40 communities had committees. All of them meet monthly for planning, and all of them have carried out at least one activity this

year. Having given the responsibility for home visits and educational sessions with mothers to the volunteers, the promoters were able to dedicate time to training and working alongside the committees. The amount and range of activities of the committees is evidence of the return on their investment. (See Section II.C., page 8, for a description of these activities.)

B. Project Expenditures

1. A pipeline analysis is attached in Appendix B.

2. The rate of expenditures compared to the budget is good. OPRODE has a good financial management system. Although costs rose above original projections because of inflation, OPRODE staff worked hard at cutting costs, and with some financial assistance from WRC has managed the situation well.

Currently inflationary pressures have been slightly reduced, and it appears that OPRODE can finish the project within its budget. It is not likely that the budget will be underspent. (Refer to the pipeline analysis in Appendix B.)

C. Lessons Learned

1. It is important that project staff be inculcated with the goals and strategies of the project from the beginning. The project's goals and strategies should be integrated with the training in Child Survival interventions given to the supervisors and promoters at the beginning of the project. The supervisors and promoters did not truly understand the goals and strategy in the DIP until the midterm evaluation. A lot of valuable time was lost in the first year and a half because of the lack of orientation.
2. In relation to number 1 above training in popular education should be given to the supervisors and promoters at the beginning of the project. This training was not given until the beginning of Year 2. The supervisors and promoters considered it crucial to their effectiveness and wished it could have been given before they began training volunteers.
3. Monthly and quarterly planning should be done in relation to specific goals in the DIP. While the staff had a general sense of the goals, they did not break them down into a timeline for monthly planning. As a result, implementation of key components was behind schedule. For example, supervisors and promoters knew that they should assign families at risk to volunteers, but the pace at which they did so was much too slow. It was only at the midterm evaluation that they realized how much they were behind schedule. If they could do it over again, they would have set monthly goals at a pace which would have had all families assigned by the end of the first year.
4. It is much more effective to assign families to volunteers based on a range of 15 to 25 families, rather than on the basis of each volunteer covering a geographic

region. Under the geographic region concept, some volunteers had a large number of mothers with children under two, while others had none. In the revised system volunteers shared the load more evenly.

5. Relationships with the MOH health centers were greatly enhanced when the promoters and volunteers helped them with concrete activities such as vaccination and sanitation campaigns. While the project staff invested a great amount of time visiting the health centers and trying to explain the project, they did not have nearly the'same effect as doing something together.

6. From the beginning of their training, volunteers should be oriented towards taking leadership in home visits and health talks. The promoters' original thought was that they would ease the volunteers into this responsibility. This tactic, however, created a sense of dependency on the promoters and took away valuable time from the promoters for working with committees and local health centers. Their slowness in turning over responsibility to the volunteers negatively affected the sustainability strategy.

II. PROJECT SUSTAINABILITY

A. Communitv Participation

This project was different from most in its sustainability strategy in that its counterpart agencies were health committees and local churches. It was an attempt to create grass-roots counterparts. It was a risky strategy in that three years is usually much too short a time for creating and strengthening such organizations. Additionally there was the risk that local churches would be partisan in their health promotion activities. The evaluation team found no evidence of partisan activities among the churches Whatever problems existed were not between the churches and the community, but rather with the church leaders' attitudes toward involvement in health activities. The project staff found that many local churches had a strongly negative attitude. At the beginning of the project, of the churches contacted, 22 were resistant or disinterested, while only 9 were supportive. By the end of the project, the number of supportive churches had grown to 21. Of these 21, however, only 7 had formed health committees. The goal was to have 14 health committees sponsored by local churches. Progress has been slow; OPRODE will have to make a definitive commitment to sustaining this process beyond the period of USAID funding.

All of the health committees have engaged in fund-raising activities in the last year. As a result, 22 committees have created their own popular pharmacies where they sell over-the-counter analgesics, antihistamines and antacids. They also distribute donated vitamins for pregnant women and children. Other committees have used the cash raised to create emergency funds or support latrine and water projects.

While the evaluation team found evidence of a good start for the grass-roots organizations, it is too early to state with certainty what the long-term results will show.

B. NGOs

The current NGO partner, OPRODE, is a full-fledged Salvadoran NGO, with a board of directors made up of four different denominations in El Salvador. They are committed to development programs, and to health programs in particular. They recognize the value of the trained personnel they have on staff, and hope to retain as many as possible and involve them in future OPRODE projects. OPRODE will continue to receive some funds from World Relief and will consider the possibility of writing a new CSP project.

OPRODE has the skilled personnel (19 promoters, 3 supervisors, a health educator and a director) to be able to develop and manage a new health project. Financially, with some help from World Relief, as well as other potential donors and churches in El Salvador, they hope to have enough income to retain at least some of their staff. They also hope to have other fund-raising activities throughout the year to help pay for staff. OPRODE is also exploring the possibility that some of the communities that benefited from the promoters' work will be able to pay a small stipend to help retain them on staff. Many of the promoters commented that now that they have learned so much, and worked so hard to build the existing health committees in their communities, they feel morally compelled to continue working in their areas, even if paid at a reduced level.

Material resources already present in OPRODE include a rented building furnished with office equipment. OPRODE as a national organization has also been able to capture funds from the local AID Mission through PROSAMI, a consortium of NGOs working on health and various other development projects.

C. Ability and Willingness of Countemart Institutions to Sustain Activities

The health communities have been quite active, particularly in the last year of the project, after a good network had been built and committees began to be involved in planning health events and taking charge of home visits, educational activities, and fund raising. Twenty-five communities have active health committees, which are involved in health education and health promotion in their communities. Some examples of the work they have been involved in include: cleaning days (wmmunity-wide days of getting rid of trash, contaminated areas), vaccination campaigns, water projects, latrine projects, road projects and emergency support in form of money, transport or medicines for people too poor to go to the doctor.

Health committees have been very involved in fund-raising activities, some of which are directly health related, such as popular pharmacies. Seven committees have a dentist wme to the community who charges on a sliding scale fee and also donates a percentage of his earnings to the health committee for their projects. One committee has arranged for a physician to wme and offer women pap smears, with the convenience of having their exam results delivered to their homes. They pay a little

extra, and those funds go to the health committee. Women like the fact that it is a female physician, they don't have to travel all the way to the MOH (extra expense and time) and they don't have to travel back for their results. They also feel like they are being treated better when the health care is provided in the community. Table 5 presents a summary of the kinds of activities organized and supported by the health committees.

Table 5: Summary of Health Committee Activities

ACTIVITIES	No. of Committees
Vaccination campaigns	25
Community clean-up campaigns	25
Health care emergency fund	25
Popular pharmacies	22
Portable water projects	11
Dental services	7
Latrine projects	6
Growth monitoring	6
Street improvement	6
Healthy school programs	4
Pap smear services	3

Three key mechanisms exist to support sustainability of the health committees. These are:

- Trained leadership
- Income generating projects
- Linkage with community governments

The most important of these is the linkage with community governments. All of the health committees have become subcommittees in the local government structure. This gives the health committees a source of encouragement and accountability that is permanent and self-sustaining. To the extent that the local governments continue to value health-related activities, the health committees will remain in existence. This linkage provides the best prospect of all for sustainability of project activities.

D. Sustainability Plan, Objectives, Steps Taken, and Outcomes

Sustainability Objectives	EOP Obj.	Steps taken to date	Outcome
Community health committees established (members meeting monthly)	40	1. Health committees formed in 25 communities by Year 2. 2. Promoters have assisted them in developing an action plan and following up on that action plan. 3. Promoters meet with health committees as often as biweekly, otherwise monthly.	25
Community health committees functioning (meet 10 months out of 12)	80%	1. 100% of health committees are functioning. 2. They are meeting monthly at a minimum.	100%
Community health committees that received a quarterly training session from promoter	80%	1. In the last year, promoters have held quarterly training sessions. 2. Promoters follow-up training in monthly meetings.	100%
Health committees with an action plan for the year (a written plan)	80%	1. Promoters review actions plans with the committees monthly. 2. Promoters assist committees in finding funding sources.	100%
Volunteers trained in the focused intervention designated for this quarter	190	1. Quarterly training established in Year 3.	100%
Community churches carry out one public health activity during the year to support health in the community	14	1. Seven churches are presently active in working with the project. 2. Health activities that they have been involved in include clinics and having health education meetings in their buildings.	7

III. EVALUATION TEAM

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